Relocating Reflective Practice

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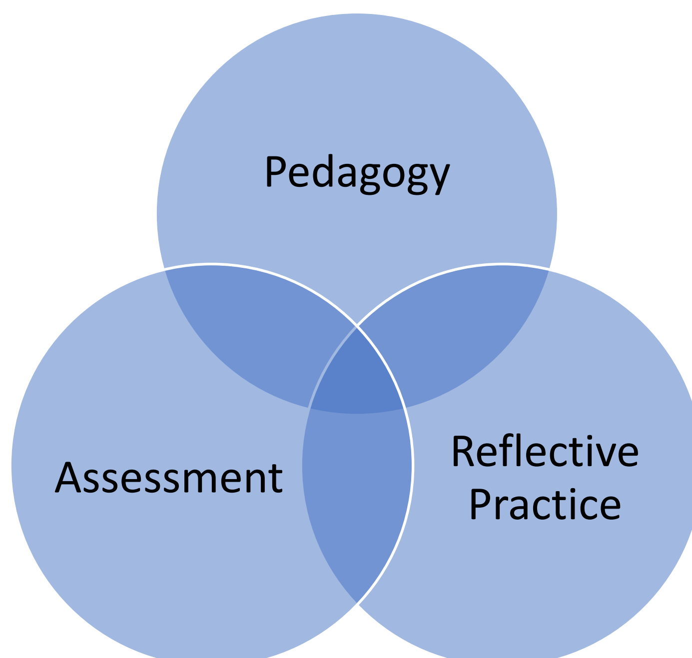
Three key concepts

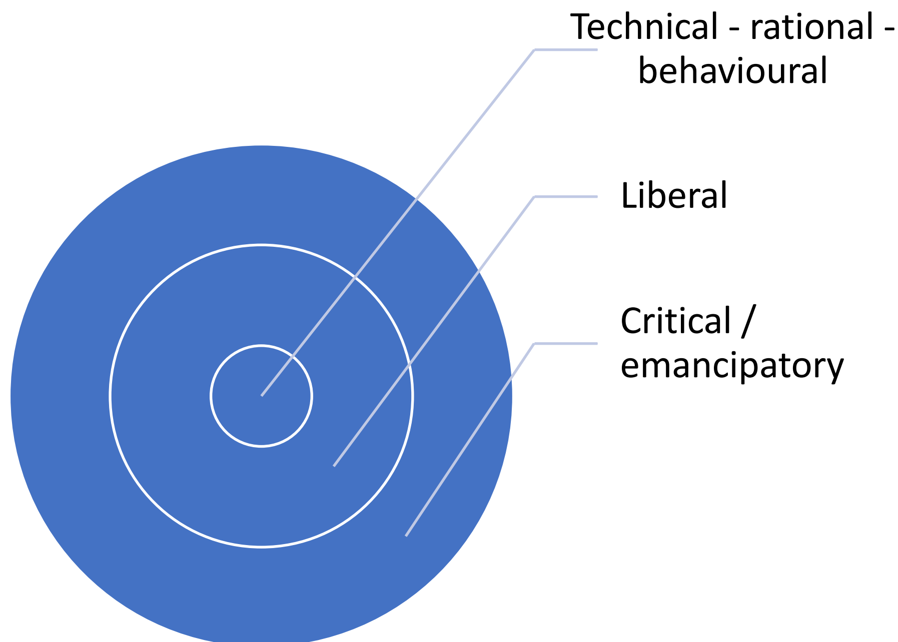
Medical education is sometimes practised rather parochially, often quite separate from mainstream educational thinking, and so I shall start by looking at the wider thinking about education that operates in our culture and informs its laws. From this perspective, Dr Bawa-Garba's case raises three issues. The first is the nature of reflective practice; the second is assessment because her reflective practice was written to be assessed; and the third is the broad educational philosophy, the pedagogy which decides the approaches taken both by reflective practice and by assessment. Of course, this is a complex matter and one which I am going to simplify for the sake of clarity. But this is our starting point: that we have an intersection of ideas that we must bring into play when we think about reflective practice *for the purposes of educational assessment*.



Pedagogy

Since it is the basis from which everything else flows, let us start with pedagogy, the educational philosophy of how teaching and learning should take place. For clarity's sake, I am going to distinguish three broad streams of thinking. They are: a technical-rational,

essentially behaviourist approach; the broad, popular approach known collectively as liberal education; and the more niche approach of critical or emancipatory pedagogy. As you can see, I have drawn these not as separate fields, or even as intersecting fields, but as an interdependence which moves from a central *part* to a larger *whole*. It is important to realise that the three approaches are not mutually exclusive, but that they do have a specific relationship: while the whole contains the part, *the part can never contain the whole*.



Conveniently, we can see the history of all three approaches arising from UK culture in the nineteenth century. First, the Industrial Revolution's shift from craft production to a factory system resulted in the so-called Taylorism and Fordism of large-scale assembly lines, which prioritised uniformity and obedience. This epitomised the technical-rational-behaviourist approach of 'training', in which there is a specifiable type of performance that has to be mastered, practice is required for its mastery, and little emphasis is placed on underlying rationale. Training's motto is 'just do it' and if a question can be answered by 'always and only do this' then you are in a training environment.

Secondly, a series of Victorian Factory Acts and Education Acts introduced compulsory schooling, building a new wave of schools for children who, hitherto, had been put to work as soon as their parents felt they could help the family income. Schools' education was largely formed on the liberal ideology of compulsory education as both a social good and a form of social engineering, enabling citizens better to enjoy or endure the culture that governed them. Part of the curriculum was still 'just do it' but a layer was added, in which learners were brought to understand principles, to grasp the rationale behind the skill or body of knowledge. This was education, rather than training, in which the answer to a question was 'it depends', where context and background were important, and choices were to be made and explained.

But what seemed absent from liberal education was the desire for learners to bring about grass-roots change in society. Unsurprisingly, then, critical pedagogy developed out of a sense of inequality and a desire for social justice. Suffragism and Fabianism brought into focus a disenfranchised intelligentsia, whose socio-economic status denied them a formal higher education, and who therefore taught and learned from each other. Where technical-rational pedagogy uses a 'delivery' approach to train people to comply with fixed standards, and liberal education uses a teacher-led approach to enable learners to assimilate culturally-sanctioned knowledge, critical pedagogy foreground social consciousness through learner-led discussions, with an aim of improving the happiness of everyone. It is a form of 'thinking-with' that develops individual and group responsibility for social change.

Pedagogy		
Technical-rational - behaviourist	Liberal	Critical / emancipatory
Training: Specified performance Little underlying rationale 'Delivery' approach instructs 'how' Imperative is 'just do it'	Education: Culturally-sanctioned Social good Teacher-led approach educates 'what' Imperative is 'it depends'	Social consciousness: To change society Thinking-with Learner-led approach questions 'why?' Imperative is 'responsibility'
Keyword: *Compliance*	Keyword: *Enjoy/ Endure*	Keyword: *Change*

Assessment

Now we have a structure for thinking about pedagogy, let us look at the implications of each approach for assessment. In our first, technical-rational model, Assessors expect to find a clearly defined and delimited set of standards against which performance can be measured. Its basis is essentially quantitative and they are seeking a measurable difference between specification and performance. The specification may be set out as a tick-list or a more complicated competence framework, but its driver is certainty. Assessment is also implicitly norm-related, that is, Assessors expect there to be a deviation from the acceptable norm, a certain percentage that, on a production line, would be designated as 'scrap' or 'rework', because no system is 100% efficient. Just as if learning really was a mechanical process that might need fine adjustments, Assessors use a language of 'tools' and 'toolkits', which aptly illustrates the instrumentalization of the learner in training environments. This is done with the best of intentions: it is a starting point for new entrants to a profession and an acknowledgement that every professional environment requires even the most senior professional to be, sometimes, a competent technician: but if this is where pedagogy ends, then it is not meeting either the practical or the ethical purposes of professional education.

A liberal pedagogy adds another layer onto the process. You must still meet the standards required by the technical-rational part of your assessment: you are not allowed to forget how to spell or to cannulate. But that is a starting point, not an end point. Assessors have a set of

criteria – this approach is called 'criterion-referenced' – and they expect that anyone who can meet those criteria will be qualified to pass the assessment: they do not norm-reference and pass only an expected percentage. Some of their criteria are qualitative, that is, they take into account the range of contexts, backgrounds, understandings, and broader possibilities that learners may explore. This is a more complex task for Assessors. Instead of a tick-list, they must meet and talk with other Assessors, discuss cases and examples and principles, and agree on what counts as acceptable. This process is known as 'moderation' and there is always a Chief Moderator, who sets the standards and makes the final call on difficult decisions. Assessors expect learners to show what lawyers call 'a margin of appreciation', a range of possible judgements, rationales, and responses: there is no one right answer. At this point, we can see what is called, technically, 'the limits of competence'. As a learning environment becomes more complex, so it becomes less and less possible to specify required behaviours precisely. If you try to do so, you enter 'the spiral of over-specification', and start drawing a map of the world that is at a 1" to 1" inch scale – it *is* the world! Instead, the language of competence fades into a new language, of 'capability' or 'entrustment', in which practice makes perfect. Exposure to this broad practice, to increasing experience of different contexts, more complex environments, other kinds of uncertainty, all takes time and is part of the purpose of the rotations that characterise postgraduate medical education.

Critical or emancipatory education takes as written the mechanics of behaviourism and the practice of liberal pedagogy and adds a further layer, sometimes called 'conscientisation'. Assessors expect learners to become critical thinkers, to ask not only what and how but also why, to refer to their ethical awareness, and to question social and professional prescriptions. Assessment become a fundamentally moral activity. Assessors will take into account the intersections of a range of ethical approaches: the consequentialism of the 'greatest good of the greatest number' foregrounded by technical-rational education; the unbreakable 'Golden Rules' which characterise deontological ethics; and especially, perhaps, the tenets of virtue ethics, which seek to advance the abilities, potential, and well-being of everyone. Now we are in the most complex of environments, where Assessors have to engage deeply with each other and with their learners, in the process of 'thinking-with' that has been typified as 'professional conversation', an urgent, on-going discussion of patients, principles, and practices, that is the hallmark of professionalism. The message is, we are all in this together, there are no easy answers, but we can work together to change at least part of the world. And in critical pedagogy, the people best positioned to make such a change are the people with the least power, whom the educationist Paulo Freire call 'the oppressed' and whose task is release both themselves *and their oppressors* from an inadequate system.[1]

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Imperative is ‘just do it’	Imperative is ‘it depends’	Imperative is ‘responsibility’
Keyword: *Compliance*	Keyword: *Enjoy/ Endure*	Keyword: *Change*
Assessment		
Defined, ‘tick-list’ standards Measurable gap Quantitative Norm-referenced Tools and toolkits Competent technician	Adds a layer: Criterion-referenced Margin of appreciation Qualitative Moderation process Increasing complexity	Adds a further layer: Questions status quo ‘Conscientisation’ Ethical intersections Professional conversation Bring about change
Keyword: *Competence*	Keyword: *Entrustment*	Keyword: *Thinking-with*

Reflective practice

At last we have a framework against which we can think about reflective practice and we shall start by listing medical education’s canonical works. In 1957, Michael Balint set out to describe case reviews he and his colleagues had carried out, in what were to become ‘Balint Groups’.[2] Their aim was to use group discussion to help each other reflect on and better understand the relationship they had with their patients, using clinical notes as objective evidence, and coming to a consensus view. Thirty years later, in 1983, Donald Schön’s *The Reflective Practitioner* separated ‘reflection in action’ – thinking about processes while actually doing them – from ‘reflection on action’ – thinking about them later to decide whether you had taken the best course possible, or whether you needed to modify your actions in the future.[3] Schön’s process for planning and eliminating problems laid the foundation for the so-called ‘Pendleton Rules’ of verbal feedback, which I first encountered as ‘first you tell me what you think you did well, then tell me what you think you did badly; then I’ll tell you what I think you did well and then what I think you did badly’.[4] These rules were an invitation to learners to first make themselves ingratiatingly or defiantly anxious and then humiliate themselves; and to teachers to patronise learners and then tell them the only thing they would remember – what they had done wrong. Pendleton’s formulation was uncomfortable at best and could be an abuse of power at worst; Schön’s approach was mechanistic, individually isolated, and fragmented; and Balint found it difficult to get consensus in his Group. But the intention of all three writers was good: they were acknowledging the necessary technical-rational elements and moving towards a liberal pedagogy.

Perhaps the turning point was 1984, when David Kolb’s Learning Cycle was used by medical education to add emphasis to technical-rational, behaviourist approaches. Kolb’s diagram presented learning as a four-stage cyclical process of experiencing an event,

reflecting on it, drawing conclusions about it, and deciding what to do in the future.[5] It was as if life took place in a completely a-contextual bubble, or as if the learner had complete control over everyone and everything, all the time. It had the click and glitter of certainty and became immensely popular in business management and medical education. It was reified by Honey and Mumford, in 1986, who used Kolb's cycle to extrapolate a deterministic idea of 'learning styles', which divided people into Activists, Reflectors, Theorists and Pragmatists.[6] People were supposed to behave in one of four stereotypical ways, irrespective of context, and everyone therefore had at least three weak areas in their ability to learn and act in a professional capacity. Perhaps inevitably, therefore, when Roger Neighbour came to write his influential *The Inner Consultation* in 1987, we see him struggling to fit his espoused ideas of intuition and feeling into a language of models, stages, categories, checkpoints, and flow-diagrams – all the impedimenta of technical-rational pedagogy and assessment.[7]

This struggle to articulate a liberal pedagogy through technical-rational approaches – which our concentric circles diagram tells us is impossible – became a defining element in medical education's writing about reflective practice. In 2009, a guide on 'The use of reflection in medical education' produced by the Association for Medical Education in Europe [AMEE] listed a range of 'models' to enable 'metacognitive thinking' and some processes for it, but was unable to articulate a coherent educational approach.[8] By 2016, John Launer was exposing the deficiencies of such approaches, pointing out that 'educational conversations do not happen in the abstract' and that they require 'a mature, equal dialogue' with 'a shared attitude of curiosity'.[9] Something of this desire for a critical pedagogy in medical education was echoed two years later, in the provocatively titled article, 'The Reflective Zombie', where two Netherlands authors argued that 'the tendency to treat reflection as something to measure and to structure contradicts the very nature of reflective thought'.[10]

But by then, in the UK, in the wake of Dr Bawa-Garba's case, new guidance had already been issued as a joint document by the Academy of Royal Colleges, the Conference of Postgraduate Medical Deans, the General Medical Council, and the Medical Schools Council. It was defensive in nature: point 9 of its 'ten key points on being a reflective practitioner' reads:

> Reflective notes can currently be required by a court. They should focus on the learning rather than a full discussion of a case or situation. Factual details should be recorded elsewhere.[11]

and two pages of guidance are given on 'Disclosure of reflective notes'. Readers were signposted to an online 'Academy and COPMeD Reflective Practice Toolkit' which, like the guidance document, shifted back to the well-known models, cycles, and learning styles of technical-rational pedagogy, turning reflection into a corrective sequence of practical steps. It is an intelligent, articulate document, its heart in liberal education although its head is concerned with recording behaviours that might safely be read out in court, and it provides a base-point from which we might start to go forward in relocating reflective practice.

Because at the moment it is in an uncomfortable location. Its focus on the individual and how they will change in the future, together with its foregrounding of simple facts, blindsides two

realities of postgraduate medical education. First, for all the rhetoric of individual responsibility, learning, and development, postgraduate doctors are operating in a complex organisational system. Second, complex mass of difficult tensions and emotions are in operation beneath the surface of that organisation, a psychodynamics that decides implicitly who can say or do what to whom. Apart from the lone voice of John Launer, the literature on reflective practice in medicine positions each postgraduate doctor as a Robinson Crusoe, with all the implications of suffering heroism that Robinsonianism implies. This is the real limitation of medicine's industrialised technical-rational model, that like the horses in George Orwell's *Animal Farm*, learners are brought to believe that problems are solved by them working harder.

A critical pedagogy would ask, where is the professional conversation that will bring about change? Answering this need, from 2005 onwards, Kent, Surrey and Sussex regional postgraduate medical Deanery instituted a system of Local Faculty Groups in its NHS Trusts. Published as *GEAR: Graduate Education and Assessment Regulations*, the system was externally evaluated in 2008 and in 2009 it was circulated to all UK deaneries.[12] Three times a year, Educational Supervisors met to discuss the progress of their learners and their learning environment. At the same time, postgraduate doctors met three times a year to share their concerns and issues, which were taken to the Local Faculty Group [LFG] for input. If the issues couldn't be resolved by the LFG itself, then its Chair would take them to the Trust's Local Academic Board [LAB], which all the LFGs reported into three times a year. Chaired by the Trust's Director of Medical Education, the LAB membership included the Medical Director, Finance, IT, and Human Resources Directors, Library Services Manager, postgraduate doctor representative, lay representative, a medical Dean and an educational expert from the Deanery. The idea was that however complex a problem might be, the necessary people were round the table to discuss and solve it, to change the way the system worked, for the benefit of learners and their patients. It was an explicit acknowledgement that if a postgraduate doctor had a problem, it was everyone's problem, and everyone had to think together to solve it.

GEAR deliberately introduced a critical pedagogy, which set out to engage the *whole organisation*, to bring about change. This dimension of relationality is constantly absent from the literature on reflective practice. Without it, all the organisational problems associated with failing technology, inadequate staffing, and managing financial stringency, are hidden. All the psychodynamic issues are also hidden: absent or unapproachable educational supervisors, hostile managers, and the turf-wars and feuds that are present in any complex organisation. Put succinctly, after the Francis Report, how can anyone find one doctor's reflective practice a matter for personal censure? As if any doctor is working in a vacuum, or as if doctors are simply obedient operatives in a production-line NHS, trained to behave as competent technicians rather than educated for a complex profession?

Of course there is a legal issue at stake here. You cannot make bricks without straw, and if there is no system in place for monitoring and managing the overall learning environment for postgraduate doctors then there are no controls on the quality of PGME. Funding for PGME is provided through a contract between NHS Trusts and what is now Health Education England [HEE], and in this exchange of considerations, postgraduate doctors have a right to

believe that their employers and HEE are between them honouring their obligation to ensure public expenditure operates to best effect. If a well-managed, quality-controlled educational environment isn't happening, and things go wrong, as they did for Dr Bawa-Garba, then who is liable? In England and Wales, at least, it feels as though the principles behind the *Corporate Manslaughter and Corporate Homicide Act* (2007) should be in play, even if the Act itself isn't legally enforceable in the NHS context. There is a similar corporate structure, with postgraduate doctors working under the supervision of Educational Supervisors, who themselves are managed by the Trust's Board-appointed Director of Medical Education, and the same sense of privatised independence, and of course, the same members of the public seeking redress for organisational failures. Why should all that responsibility rest on one doctor's shoulders and be shuffled-off to the GMC and the incongruities of the 1983 *Medical Act*, when thirty-five years later, we are living in a quite different society with quite different expectations of rights and responsibilities?

But leaving aside the legalities, and even the ethics of isolating reflective practice into a solely individual activity with a purely personal responsibility, how can we go forward? What are the standpoints, principles, and processes that we can use to relocate reflective practice, to stop it sliding back into a desperate, inauthentic behaviourism, and to introduce a critical pedagogy that will bring about change, for learners, their teachers, managers, and above all, for the improvement of patient care? It seems to me that reflective practice needs to be relocated as 'reflexivity'. Reflexivity is an integral part of action, a production of knowledge that is inseparable from the actor producing it. 'Reflection' is framed as a static, quasi-historical formal account of an apparently objective event, like a still photograph. People are caught in awkward positions as if they were the only positions they ever occupied. Reflexivity accepts that people continue to act without stopping, and without necessarily being able to describe precisely why they act, why events happen and why they respond to them in a particular way, since knowledge production is not static but fluid, continuous, contextual, and rapidly changing. This was the real situation for everyone involved in Dr Bawa-Garba's case – including the GMC – and it needs to be acknowledged. There is hope ahead. A new generation of doctors have started to write in these more complex ways, and the public are gaining new insights into medicine: in particular, though, reflexive practice seems to me to be epitomised by the emergent genre of graphic medicine, with its sophisticated use of image and dialogue, as in this extract from Thom Ferrier's *Fear of Failure*, featuring Dr Lois Pritchard.[13]

Here you can see the reflexive responses arising from Lois's lunchtime walk through her small town, the conscious ones above and the subconscious ones recorded below, all this embodied, interactive, moving knowledge then reduced to a diary entry.

Acknowledging this kind of richly-textured narrative is the basis for relocating reflective practice into reflexivity, for shifting from technical-rationalism's thin description into the thick descriptions and direct actions of critical pedagogy, and for acknowledging the complexities of postgraduate medical education and managing them appropriately. Education is constantly remade in reflexive praxis, an ongoing activity in a dynamic present which honours a perpetual becoming, in sharp contrast to the static past of dim, frozen images, that are the stock-in-trade of medicine's reflective practice. Finding the new viewpoints, new perspectives, and new ways of understanding the world, which informs such a reflexive praxis is, I believe, the role of medical humanities.

Zoë Playdon
7 December 2018

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[1] Paulo Freire, *Pedagogy of the Oppressed*, translated by Myre Bergman Ramos (London: Continuum, 1970).
[2] M Balint, *The Doctor, His Patient and the Illness* (London: Pitman, 1957).
[3] D A Schön, *The Reflective Practitioner* (London: Temple Smith, 1983).
[4] David Pendleton, Theo Schofield, Peter Tate and Peter Havelock, *The Consultation: An Approach to Learning and Teaching* (Oxford: Oxford University Press, 1983).
[5] David A Kolb, *Experiential Learning* (Englewood Cliffs: Prentice Hall, 1984).
[6] P Honey and A Mumford, *The Manual of Learning Styles* (Maidenhead: Peter Honey Associates, 1986).
[7] Roger Neighbour, *The Inner Consultation* (London: Kluwer Academic Publishers, 1987).
[8] John Sandars, 'The use of reflection in medical education: AMEE Gide No 44', *Medical Teacher*, 31, 2009, 685-695.
[9] John Launer, 'Giving feedback to medical students and trainees: rules and realities', *Postgraduate Medical Journal*, Vol. 92, Issue 1092, 627-628, p. 627.
[10] Anne de la Croix and Mario Veen, 'The reflective zombie: Problematizing the conceptual framework of reflection in medical education', *Perspectives on Medical Education*, 23 October 2018, 1-7, p. 5.
[11] Academy of Royal Colleges, Conference of Postgraduate Medical Deans, General Medical Council and Medical Schools Council, *The Reflective Practitioner: Guidance for doctors and medical students*, published on-line https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/the-reflective-practitioner---guidance-for-doctors-and-medical-students
[12] Available at http://cmec.info/wp-content/uploads/2011/08/GEAR_Final_Version_2105.pdf
[13] Thom Ferrier, *Fear of Failure: Episode #1I* (Graphic Medicine: Llanrhaeadr, Denbighshire, 2010).